I

105TH CONGRESS
1ST SESSION

H. R. 2967

To amend the title XXVII of the Public Health Service Act and other laws to assure the rights of enrollees under managed care plans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 8, 1997

Mr. SCHUMER introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the title XXVII of the Public Health Service Act and other laws to assure the rights of enrollees under managed care plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Consumer's Bill of Rights Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

SEC. 101. HEALTH INSURANCE BILL OF RIGHTS.

Title XXVII of the Public Health Service Act is amended—

(1) by redesignating part C as part D, and

(2) by inserting after part B the following new part:

''PART C—HEALTH INSURANCE BILL OF RIGHTS

"SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS.

''(a) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this part as if such section applied to such issuer and such issuer were a group health plan.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this part:

''(1) ENROLLEE.—The term 'enrollee' means an individual who is entitled to benefits under a group health plan or under health insurance coverage.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means a physician or other

health care practitioner providing health care services.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means a clinic, hospital physician organization, preferred provider organization, independent practice association, community service provider, family planning clinic, or other appropriately licensed provider of health care services or supplies.

''(4) MANAGED CARE.—The term 'managed care' means, with respect to a group health plan or health insurance coverage, such a plan or coverage that provides financial incentives for enrollees to obtain benefits through participating health care providers or professionals.

''(5) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider or professional and a group health plan or health insurance coverage, such a provider or professional that is not a participating provider or professional with respect to such services.

''(6) PARTICIPATING.—The term 'participating' means, with respect to a health care provider or professional and a group health plan or health insurance coverage offered by a health insurance issuer,

such a provider or professional that has entered into an agreement or arrangement with the plan or issuer with respect to the provision of health care services to enrollees under the plan or coverage.

''(7) PRIMARY CARE PRACTITIONER.—The term 'primary care practitioner' means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer, a health care professional (who may be trained in family practice, general practice, internal medicine, obstetrics and gynecology, or pediatrics and who is practicing within the scope of practice authorized by State law) designated by the plan or issuer to coordinate, supervise, or provide ongoing care to enrollees.

''SUBPART 1—ACCESS TO PRIMARY CARE PHYSICIANS, SPECIALISTS, OUT OF NETWORK PROVIDERS, EMERGENCY ROOM SERVICES, PRESCRIPTION DRUGS

''SEC. 2771. ACCESS TO PERSONNEL AND FACILITIES; ASSURING ADEQUATE CHOICE OF HEALTH CARE PROFESSIONALS.

''A managed care group health plan (and a health insurance issuer offering managed care group health insurance coverage) shall comply with regulations promul-

gated by the Secretary that ensure that such plans and issuers—

''(1) have a sufficient number and type of primary care practitioners and specialists, throughout the service area to meet the needs of enrollees and to provide meaningful choice;

''(2) maintain a mix of primary care practitioners that is adequate to meet the needs of the enrollees' varied characteristics, including age, gender, race, and health status; and

''(3) include, to the extent possible, a variety of primary care providers (including community health centers, rural health clinics, and family planning clinics).

''SEC. 2772. ACCESS TO SPECIALTY CARE.

''A managed care group health plan (and a health insurance issuer offering managed care group health insurance coverage) shall comply with regulations promulgated by the Secretary that ensure that such plans and issuers provide enrollees with—

''(1) access to specialty care;

''(2) standing referrals to specialists;

''(3) access to nonparticipating providers;

''(4) direct access (without the need for a referral) to health care professionals trained in obstetrics and gynecology; and

''(5) a process that permits a health care professional trained in obstetrics and gynecology or other field appropriate to women's health to be designated and treated as a primary care practitioner.

"SEC. 2773. ACCESS TO EMERGENCY CARE.

''(a) IN GENERAL.—If a group health plan or health insurance coverage provides any benefits with respect to emergency services (as defined in subsection (b)(1)), the plan or the health insurance issuer offering such coverage shall—

''(1) provide for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization; and

''(2) comply with such guidelines as the Secretary of Health and Human Services may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867 of the Social Security Act.

''(b) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(1) IN GENERAL.—The term 'emergency services' means, with respect to an enrollee under a plan or coverage, inpatient and outpatient services covered under the plan or coverage that—

''(A) are furnished by a provider that is qualified to furnish such services under the plan or coverage, and

''(B) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(2) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

''SEC. 2774. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

''(a) IN GENERAL.—If a group health plan provides benefits, or a health insurance issuer offers health insurance coverage to, a qualified enrollee (as defined in subsection (b)), the plan or issuer—

''(1) may not deny the enrollee participation in the clinical trial referred to in subsection (b)(2);

''(2) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(3) may not discriminate against the enrollee on the basis of the enrollee's participation in such trial.

''(b) QUALIFIED ENROLLEE DEFINED.—For purposes of subsection (a), the term 'qualified enrollee' means an enrollee who meets the following conditions:

''(1) The enrollee has a life-threatening or serious illness for which no standard treatment is effective.

''(2) The enrollee is eligible to participate in an approved clinical trial with respect to treatment of such illness.

''(3) The enrollee and the referring physician conclude that the enrollee's participation in such trial would be appropriate.

''(4) The enrollee's participation in the trial offers potential for significant clinical benefit for the enrollee.

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a plan or issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

''(2) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a clinical research study or clinical investigation approved by the Food and Drug Administration or approved and funded by one or more of the following:

''(1) The National Institutes of Health.

''(2) A cooperative group or center of the National Institutes of Health.

''(3) The Department of Veterans Affairs.

''(4) The Department of Defense.

''SEC. 2775. CONTINUITY OF CARE.

''A managed care group health plan (and a health insurance issuer offering managed care group health insurance coverage) shall comply with regulations promulgated by the Secretary that ensure that such plans and issuers provide continuity of coverage in the case of terminated coverage where an enrollee is undergoing a course of treatment with the provider at the time of such termination.

"SEC. 2776. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer (offering health insurance coverage in connection with a group health plan) and a health professional shall not prohibit or restrict the health professional from engaging in medical communications with his or her patient.

''(b) NULLIFICATION.—Any contract provision or agreement described in subsection (a) shall be null and void.

''(c) MEDICAL COMMUNICATION DEFINED.—For purposes of this section, the term 'medical communication' has the meaning given such term by the Secretary.

"SEC. 2777. ACCESS TO NEEDED PRESCRIPTION DRUGS.

''If a group health plan, or health insurance issuer offers health insurance coverage that, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall ensure in accordance with regulations of the Secretary that—

''(1) the nature of the formulary restrictions is fully disclosed to enrollees; and

''(2) exceptions from the formulary restriction are provided when medically necessary or appropriate.

''SUBPART 2—UTILIZATION REVIEW, GRIEVANCE, APPEALS, AND QUALITY IMPROVEMENT

"SEC. 2779. STANDARDS FOR UTILIZATION REVIEW ACTIVITIES, COMPLAINTS, AND APPEALS.

''A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan shall comply with standards established by the Secretary relating to its conduct of utilization review activities. Such standards shall include the following:

''(1) A requirement that a plan or issuer develop written policies and criteria concerning utilization review activities.

''(2) A requirement that a plan or issuer provide notice of such policies and criteria and the written notice of adverse determinations.

''(3) A restriction on the use of contingent compensation arrangements with providers.

''(4) A requirement establishing deadlines to ensure timely utilization review determinations.

''(5) The establishment of an adequate process for filing complaints, and appealing decisions, concerning utilization review determinations, including

the mandatory use of an outside review panel to make decisions on such appeals.

''(6) A requirement that a plan or issuer that utilizes clinical practice guidelines uniform apply review criteria that are based on sound scientific principles and the most recent medical evidence.

''SEC. 2780. QUALITY IMPROVEMENT PROGRAM.

''(a) IN GENERAL.—A group health plan and health insurance issuer offering health insurance coverage shall make arrangements for an ongoing quality improvement program for health care services it provides to enrollees. Such a program shall meet standards established by the Secretary, including standards relating to—

''(1) the measurement of health outcomes relevant to all populations, including women;

''(2) evaluation of high risk services;

''(3) monitoring utilization, underutilization, and overutilization of services;

''(4) ensuring appropriate action to improve quality of care; and

''(5) providing for an independent external review of the program.

''SUBPART 3—NONDISCRIMINATION

''SEC. 2784. NONDISCRIMINATION.

''(a) ENROLLEES.—A group health plan or health insurance issuer offering health insurance coverage (whether or not a managed care plan or coverage) may not discriminate or engage (directly or through contractual arrangements) in any activity, including the selection of service area, that has the effect of discriminating against an individual on the basis of race, culture, national origin, gender, sexual orientation, language, socio-economic status, age, disability, genetic makeup, health status, anticipated need for health care services, or payer source.

''(b) PROVIDERS.—Such a plan or issuer may not discriminate in the selection of members of the health provider or provider network (and in establishing the terms and conditions for membership in the network) of the plan or coverage based on any of the factors described in subsection (a).

''(c) SERVICES.—Such a plan or issuer may not exclude coverage (including procedures and drugs) if the effect is to discriminate in violation of subsection (a) or (b).

''SUBPART 4—CONFIDENTIALITY

''SEC. 2785. MEDICAL RECORDS AND CONFIDENTIALITY.

''A managed care group health plan (and a health insurance issuer offering managed care group health insurance) shall—

''(1) establish written policies and procedures for the handling of medical records and enrollee communications to ensure enrollee confidentiality;

''(2) ensure the confidentiality of specified enrollee information, including, prior medical history, medical record information and claims information, except where disclosure of this information is required by law; and

''(3) not release any individual patient record information, unless such a release is authorized in writing by the enrollee or otherwise required by law.

''SUBPART 5—DISCLOSURES

''SEC. 2786. HEALTH PROSPECTUS; DISCLOSURE OF INFORMATION.

''(a) DISCLOSURE.—Each group health plan, and each health insurance issuer providing health insurance coverage, shall provide to each enrollee at the time of enrollment and on an annual basis, and shall make available to each prospective enrollee upon request—

''(1) a prospectus that relates to the plan or coverage offered and that meets the requirements of subsection (b); and

''(2) additional information described in subsection (c).

''(b) PROSPECTUS.—

''(1) IN GENERAL.—Each prospectus under this subsection for a plan or coverage—

''(A) shall contain the information described in paragraphs (2) through (4) concerning the plan or coverage,

''(B) shall contain such additional information as the Secretary deems appropriate, and

''(C) shall be no longer than 3 pages in length and in a format specified by the Secretary for purposes of comparison by prospective enrollees.

''(2) QUALITATIVE INFORMATION.—The information described in this paragraph is a summary of the quality assessment data on the plan or coverage. The data shall—

''(A) be the similar to the types of data as are collected for managed care plans under title XVIII of the Social Security Act, as determined by the Secretary and taking into account dif-

ferences between the populations covered under such title and the populations covered under this title;

"(B) be collected by independent, auditing agencies;

"(C) include—

"(i) a description of the types of methodologies (including capitation, financial incentive or bonuses, fee-for-service, salary, and withholds) used by the plan or issuer to reimburse physicians, including the proportions of physicians who have each of these types of arrangements; and

"(ii) cost-sharing requirements for enrollees.

The information under subparagraph (C) shall include, upon request, information on the reimbursement methodology used by the plan or issuer or medical groups for individual physicians, but do not require the disclosure of specific reimbursement rates.

"(3) QUANTITATIVE INFORMATION.—The information described in this paragraph is measures of performance of the plan or issuer (in relation to coverage offered) with respect to each of the following

and such other salient data as the Secretary may specify:

"(A) The ratio of physicians to enrollees, including the ratio of physicians who are obstetrician/gynecologists to adult, female enrollees.

"(B) The ratio of specialists to enrollees.

"(C) The incentive structure used for payment of primary care physicians and specialists.

"(D) Patient outcomes for procedures, including procedures specific to female enrollees.

"(E) The number of grievances filed under the plan or coverage.

"(F) The number of requests for procedures for which utilization review board review or approval is required and the number (and percentage) of such requests that are denied.

"(G) The number of appeals filed from denial of such requests and the number (and percentage) of such appeals that are approved, such numbers and percentages broken down by gender of the enrollee involved.

"(H) Disenrollment data.

"(4) DESCRIPTION OF BENEFITS.—The information described in this paragraph is a description of the benefits provided under the plan or coverage,

as well as explicit exclusions, including a description of the following:

''(A) Coverage policy with respect to coverage for female-specific benefits, including screening mammography, hormone replacement therapy, bone density testing, osteoporosis screening, maternity care, and reconstructive surgery following a mastectomy.

''(B) The costs of copayments for treatments, including any exceptions.

''(c) ADDITIONAL INFORMATION.—The additional information described in this subsection is information about each of the following:

''(1) The plan's or issuer's structure and provider network, including the names and credentials of physicians in the network.

''(2) Coverage provided and excluded, including out-of-area coverage.

''(3) Procedures for utilization management.

''(4) Procedures for determining coverage for investigational or experimental treatments, as well as definitions for coverage terms.

''(5) Any restrictive formularies or prior approval requirements for obtaining prescription drugs,

including, upon request, information on whether or not specific drugs are covered.

''(6) Use of voluntary or mandatory arbitration.

''(7) Procedures for receiving emergency care and out-of-network services when those services are not available in the network and information on the coverage of emergency services, including—

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(B) the process and procedures for obtaining emergency services; and

''(C) the locations of (i) emergency departments, and (ii) other settings, in which physicians and hospitals provide emergency services and post-stabilization care.

''(8) How to contact agencies that regulate the plan or issuer.

''(9) How to contact consumer assistance agencies, such as ombudsmen programs.

''(10) How to obtain covered services.

''(11) How to receive preventive health services and health education.

''(12) How to select providers and obtain referrals.

''(13) How to appeal health plan decisions and file grievances.

''(d) STATE AUTHORITY TO REQUIRE ADDITIONAL INFORMATION.—

''(1) IN GENERAL.—Subject to paragraph (2), this section shall not be construed as preventing a State from requiring health insurance issuers, in relation to their offering of health insurance coverage, to disclose separately information (including comparative ratings of health insurance coverage) in addition to the information required to be disclosed under this section.

''(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

''SUBPART 6—PROMOTING GOOD MEDICAL PRACTICE AND PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

''SEC. 2787. PROMOTING GOOD MEDICAL PRACTICE.

''(a) PROHIBITING ARBITRARY LIMITATIONS OR CONDITIONS FOR THE PROVISION OF SERVICES.—A group health plan and a health insurance issuer, in connection with the provision of health insurance coverage,

may not impose limits on the manner in which particular services are delivered if the services are medically necessary or appropriate to the extent that such procedure or treatment is otherwise a covered benefit.

''(b) CONSTRUCTION.—Subsection (a) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the coverage.''.

TITLE II—APPLICATION OF BILL OF RIGHTS UNDER VARIOUS LAWS

SEC. 201. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. MANAGED CARE REQUIREMENTS.

''Each health insurance issuer shall comply with the applicable requirements under part C with respect to group health insurance coverage it offers.''.

(b) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. MANAGED CARE REQUIREMENTS.

''Each health insurance issuer shall comply with the applicable requirements under part C with respect to individual health insurance coverage it offers, in the same manner as such requirements apply to group health insurance coverage.''.

(c) MODIFICATION OF PREEMPTION STANDARDS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Section 2723 of such Act (42 U.S.C. 300gg–23) is amended—

(A) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES IN CASE OF MANAGED CARE REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2706 and part C, and part D insofar as it applies to section 2706 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such provisions.''.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of such Act (42 U.S.C. 300gg–62), as added by section 605(b)(3)(B) of Public Law 104–204, is amended—

(A) in subsection (a), by striking ''subsection (b), nothing in this part'' and inserting ''subsections (b) and (c)'', and

(B) by adding at the end the following new subsection:

''(c) SPECIAL RULES IN CASE OF MANAGED CARE REQUIREMENTS.—Subject to subsection (b), the provisions of section 2752 and part C, and part D insofar as it applies to section 2752 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such section.''.

(d) ADDITIONAL CONFORMING AMENDMENTS.—

(1) Section 2723(a)(1) of such Act (42 U.S.C. 300gg–23(a)(1)) is amended by striking ''part C'' and inserting ''parts C and D''.

(2) Section 2762(b)(1) of such Act (42 U.S.C. 300gg–62(b)(1)) is amended by striking ''part C'' and inserting ''part D''.

(e) ASSURING COORDINATION.—Section 104(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) is amended by striking ''under this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''title XXVII of the Public Health Service Act, under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and chapter 100 of the Internal Revenue Code of 1986''.

SEC. 202. MANAGED CARE REQUIREMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 713. MANAGED CARE REQUIREMENTS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act.

''(b) REFERENCES IN APPLICATION.—In applying subsection (a) under this part, any reference in such part C—

''(1) to a health insurance issuer and health insurance coverage offered by such an issuer is deemed to include a reference to a group health plan and coverage under such plan, respectively;

''(2) to the Secretary is deemed a reference to the Secretary of Labor;

''(3) to an applicable State authority is deemed a reference to the Secretary of Labor; and

''(4) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.''.

(b) MODIFICATION OF PREEMPTION STANDARDS.—Section 731 of such Act (42 U.S.C. 1191) is amended—

(1) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES IN CASE OF MANAGED CARE REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 713 and part C of title XXVII of the Public Health Service Act, and subpart C insofar as it applies to section 713 or such part, shall not be construed to pre-

empt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Managed care requirements.''.

SEC. 203. MANAGED CARE REQUIREMENTS UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Subchapter B of part B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 9813. MANAGED CARE REQUIREMENTS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act.

''(b) REFERENCES IN APPLICATION.—In applying subsection (a) under this subchapter, any reference in such part C—

''(1) to the Secretary is deemed a reference to the Secretary of the Treasury; and

''(2) to an applicable State authority is deemed a reference to the Secretary.''.

(b) CLERICAL AMENDMENT.—The table of sections in subchapter B of chapter 100 of such Code is amended by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Managed care requirements.''.

SEC. 204. MANAGED CARE REQUIREMENTS UNDER MEDICARE, MEDICAID, AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).

(a) MEDICARE.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22), as inserted by section 4001 of the Balanced Budget Act of 1997 (Public Law 101–33), is amended by adding at the end the following new subsection:

''(l) MANAGED CARE REQUIREMENTS.—Each Medicare+Choice organization that offers a Medicare+Choice plan described in section 1851(a)(1)(A) shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act in the same manner as such requirements apply with respect to health insurance coverage offered by a health insurance issuer, except to the extent such requirements are less pro-

tective of enrollees than the requirements established under this part.''.

(b) MEDICAID.—Section 1932(b)(8) of the Social Security Act, as added by section 4704(a) of the Balanced Budget Act of 1997, is amended—

(1) by striking ''AND MENTAL HEALTH'' and inserting '', MENTAL HEALTH, AND MANAGED CARE'',

(2) by inserting ''and of part C'' after ''of part A'', and

(3) by inserting before the period at the end the following: '', except to the extent such requirements are less protective of enrollees than the requirements established under this title''.

(c) FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM (FEHBP).—Chapter 89 of title 5, United States Code, is amended—

(1) by inserting after the item relating to section 8905a the following new section:

''§ 8905b. Application of managed care requirements

''Each health benefit plan offered under this chapter shall comply with the applicable requirements of part C of title XXVII of the Public Health Service Act in the same manner as such requirements apply with respect to health insurance coverage offered by a health insurance issuer, except to the extent such requirements are less pro-

tective of enrollees than the requirements established under this chapter.''; and

(2) in the table of sections, by inserting the following item after the item relating to section 8905a:

''8905b. Application of managed care requirements.''.

SEC. 205. EFFECTIVE DATES.

(a) GENERAL EFFECTIVE DATE FOR GROUP HEALTH PLANS.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by section 101, subsections (a), (c)(1), and (d) of section 201, and sections 203 and 204 shall apply with respect to group health insurance coverage for group health plan years beginning on or after July 1, 1998 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after January 1, 1999.

(2) TREATMENT OF GROUP HEALTH PLANS MAINTAINED PURSUANT TO CERTAIN COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan, or group health insurance coverage provided pursuant to a group health plan, maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments described in paragraph

(1) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by such amendments shall not be treated as a termination of such collective bargaining agreement.

(b) GENERAL EFFECTIVE DATE FOR HEALTH INSURANCE COVERAGE.—The amendments made by section 101 and subsections (b), (c)(2), and (d) of section 201 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) EFFECTIVE DATE FOR COORDINATION.—The amendment made by section 201(e) shall take effect on the date of the enactment of this Act.

(d) FEDERAL PROGRAMS.—The amendments made by section 204 shall take effect on January 1, 1999.

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